IMPACT REFERRAL

State Form 46755 (R / 4-97) / IMP 0004

	Last name:	
	First name:	
Program (*check one*) ☐ TANF ☐ TANF-UP ☐ F.S.	Street address:	MI:
	City:	
TANF Group (*check one*) ☐ Control ☐ Treatment	State:	ZIP code:
	Telephone number: ( )	Social Security number
Provider referred to:		Contact person:
Provider address: (*number and street, city, state, ZIP code*)		
		Provider telephone number: ( )

Service group	Service object code	Component service	Time / Date of appointment:
Comments:			Printed name of case manager:
			Signature of case manager:
			Case manager telephone number: ( ) — Date:

PROVIDER RESPONSE

_____ kept / did not keep their appointment on _____ at _____ .
(client's name) (time)

The client has been assigned to _____ beginning _____ at _____ .
(activity) (date) (time)

The activity will end on _____ .
(date)

The client was not assigned to an activity because:

Additional comments:

Printed name of authorized provider	Signature of authorized provider

Return this form to local IMPACT office
(*stamped to the right*)

no later than _____
(date)

DISTRIBUTION: White - Provider; Canary - Client; Pink - Case Record